Results: 201 patients recruited by 19 Spanish gastroenterologists were included. 55.7% were male and mean (SD) age was 38.9 (12.3) years. The mean (SD) disease duration was 8.6 (8.1) years. Most of the patients had disease in the terminal ileum (L1: 42.3%), with a non-structuring, non-penetrating behaviour (B1: 54.7%). Perianal disease was present in 41 (20.4%) patients. 102 patients (50.7%) were in clinical remission. Scenarios E and (B1: 54.7%). Perianal disease was present in 41 (20.4%) patients. 102 patients (50.7%) were in clinical remission. Scenarios E and F were the most preferred (57.3% and 53.7% respectively). The least preferred was scenario A (19.9%). Treatment administered by healthcare personnel (0.155), treatment administered at home (0.485) and subcutaneous treatments (0.053) were considered the most useful. These scores indicate the value of each characteristic has been perceived by patients [from 1 (high) to 0 (low)]. And the result of the most influence factor when choosing a CD therapy is the place where the treatment is administered with an importance of 50.7%.

Conclusions: A validated questionnaire to evaluate patient's preferences has been applied to CD patients, enabling involvement of the patient in treatment making decisions, which could have the benefit of improving adherence and effectiveness. The results demonstrated that treatment administered at home had the greatest impact on preferences.

P308 Treatment of corticosteroid naïve children and adolescents with ulcerative colitis by adsorptive depletion of myeloid lineage leucocytes as monotherapy or in combination with low dose prednisolone after failure of first-line medications 
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Background: Given that patients with active ulcerative colitis (UC) have elevated and activated myeloid lineage leucocytes including the CD14+CD16+ monocyte phenotype known to release TNF-α, selective depletion of these leucocytes by granulocyte and monocyte adsorption (GMA) should be therapeutic in UC patients. This strategy is most relevant in growing young patients. This study was to evaluate the efficacy of GMA in children and adolescents with active UC in whom conventional first-line medications had failed to induce remission.

Methods: In a single centre setting, between 2010 and 2013, a total of 25 consecutive children and adolescents, age 11–19 years, body weight 33–55 kg were given mesalazine or sulphasalazine as a first-line medication. Eighteen patients relapsed or did not respond and received GMA with the Adacolumn, 2 sessions in the first week, then weekly, up to 11 sessions. Patients who achieved a decrease of ≥5 in the clinical activity index (CAI) were to continue with GMA, while non-responders were to receive 0.5 to 1.0 mg/kg/day prednisolone (PSL) plus additional GMA sessions. At entry and week 12, patients were clinically and endoscopically evaluated, allowing each patient to serve as her/his own control.

Results: At entry, all 25 patients were corticosteroid naïve and none had deep colonic UC lesions together with extensive loss of the mucosal tissue at the affected sites. Seven patients achieved remission with the first-line medications and did not receive GMA. Six patients did not respond well to the first 5 GMA sessions and received PSL plus GMA, while 12 patients responded to the first 5 GMA sessions and received additional sessions. At entry, the average CAI was 14.1 ± 0.4, range 11–17, and the average endoscopic index was 9.2 ± 0.3, range 7–11. The corresponding values at week 12 were 2.1 ± 0.2, range 1–4 (P < 0.001) and 2.4 ± 0.2, range 1–4 (P < 0.001). PSL was tapered to 0 mg within 3 months. Therefore, at week 12, all 25 patients had achieved clinical remission, majority with mucosal healing (complete remission).

Conclusions: GMA in patients with deep ulcers together with extensive loss of the mucosal tissue (a major GMA non-respondent feature) has not been associated with adequate efficacy. However, in this study, GMA in young corticosteroid naïve patients with active UC refractory to the first-line medications was associated with clinical remission and mucosal healing, while in non-responders to GMA monotherapy, addition of a low dose PSL enhanced the efficacy of GMA and tapering of the PSL dose was not associated with UC relapse. Therefore, the majority of young steroid naïve UC patients who fail to respond to the first-line medication should respond to GMA and be spared from pharmacological intervention.

P309 Transition experience from inpatient to ambulatory IBD care: Results of a pilot study
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Background: Management of inflammatory bowel disease (IBD) is inherently multidisciplinary and often fragmented. Despite advances in therapy, many patients will require hospital admission and 50% will require at least one surgery to manage their disease. The transition from inpatient to outpatient care is a vulnerable time for patients. Healthcare transition periods are associated with poorer health outcomes, and a structured transition program may improve compliance and disease control.

Methods: We conducted a prospective survey of 67 adults with IBD transitioning from inpatient to ambulatory care in order to better understand their experiences and how their transition can be improved. We used validated instruments to assess satisfaction with transition and medical care, self-perceived physical and mental health status, as well as health-related quality of life at transition.

Results: 26 subjects (38.8%) provided adequate data for analysis, of whom 18 (69.2%) had Crohn’s disease and 8 (30.8%) had ulcerative colitis. The mean age at transition was 43 ± 17 years. The median disease duration was 10 years (range 0.25–30). 9 hospitalizations (34.6%) were medical and 17 (65.4%) were surgical, with median lengths of stay 5.5 (range 1–15) and 8.5 (range 5–62) days, respectively. Responses to the Inflammatory Bowel Disease Questionnaire (IBDQ) showed that quality of life at transition was good for 10 subjects (35%), regular for 12 (46.2%), and bad for 4 (15.4%). Compared to normative Canadian data, SF36 scores from our subjects demonstrated decreased physical and social functioning, general health, emotional health and well-being with increased pain and fatigue. Using the Care Transitions Measure 15 (CTM-15), 16 subjects (61.5%) reported the quality of their care transition to be good and 5 (19.2%) reported it to be excellent. Mean domain scores from the Patient Satisfaction Questionnaire (PSQ) were 2.88 (SD 1.77) for general satisfaction, 3.01 (SD 1.60) for technical quality, 3.42 (SD 1.72) for interpersonal manner, 2.44 (SD 1.87) for communication, 2.73 (SD 1.55) for financial aspects, 2.50 (SD 1.75) for time with the doctor, and 2.81 (SD 1.72) for accessibility.

Conclusions: There is a clear need for transition strategies that help adults with IBD manage their disease after discharge from hospitalisation.
the hospital and during their transition back to ambulatory care. Strategies to bridge this gap have not been formally evaluated. These data assess the outcome of inpatient to ambulatory care transition under our current standard of care. The McMaster University/Hamilton Health Sciences IBD Clinic is exploring a formal transition program led by a dedicated IBD nurse practitioner. Our outcomes will be reassessed following introduction of this pilot program.

P310
Toxicity of thiopurines in patients with inflammatory bowel disease: Frequency and risk factors

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Background: The aim of our study was to assess safety of thiopurine therapy in inflammatory bowel disease (IBD) patients and to determine risk factors for adverse events (AE) through a retrospective Tunisian cohort.

Methods: We have conducted a retrospective study including IBD patients treated with thiopurines from 2006 and 2012. Epidemiologic, clinical and therapeutic characteristics were abstracted from medical records. Thiopurine-related AE were sought in each patient. Data entry and analysis were performed by ssps version 21.0.

Results: We have collaged 210 patients (98 males and 112 females) of mean age of 29.8 years old (8-62). One hundred sixty-nine patients (80.5%) had Crohn’s disease, 27 (12.9%) had ulcerative colitis and 12 (5.7%) had unclassified colitis. AZT and 6MP were prescribed respectively in 206 (98.1%) and 19 (9%) patients. Indicators for thiopurines were mainly as maintenance therapy after severe acute colitis in 79 patients (37.6%), prevention of postoperative recurrence of CD in 51 patients (24.4%) and corticosteroid-dependent (CD) IBD in 37 patients (17.6%). During a mean follow-up period of 28.4 months, digestive intolerance (DI) of AZT was noted in 14 patients after 5 months of treatment leading to a switch to 6MP in 10 patients. Immunoallergic reactions occurred in 8 patients [acute pancreatitis (n = 5), cutaneous rash (n = 3)]. Hematologic toxicity was seen in 23 patients after 20 months (2-80) of treatment: lymphopenia (n = 19), neutropenia (n = 11), anemia (n = 15) and thrombopenia (n = 11). Six patients had hepatic toxicity: cholestasis at 3 times the upper limit of normal (ULN) resulting in a dose reduction in 3 patients. Acute hepatic cytolysis at 3 to 9 times ULN occurred in 4 patients after ruling out a viral origin. Regenerative nodular hyperplasia was seen in only 1 patient. There have been one case of acute myeloid leukemia diagnosed 3 months after AZT onset. In univariate analysis, CD patients had significantly less AE (30% vs 70%, p = 0.008). Patients with corticosteroid-resistance profile had less AE with trend to marginal significance (6% vs 94%, p = 0.08). Patients who had extensive ileal involvement and who were more than 20 years old at disease onset developed (DI) less rapidly (respectively p = 0.06 and p = 0.04). Immunoallergic reactions seem to occur less commonly among patients who had previously treated with corticosteroids (p = 0.09).

Conclusions: Use of thiopurines in patients with IBD is overall safe. Hematologic and hepatic toxicities are the most common AE. Clinicians should consider these side effects to optimize thiopurine therapy in IBD patients.

P311
Thiopurine metabolite monitoring and allopurinol combination therapy: current utilisation and influence on Australian gastroenterology IBD practice

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Background: Thiopurines (TP) are a mainstay of inflammatory bowel disease (IBD) management. Thiopurine methyltransferase (TPMT) testing and TP metabolites monitoring have been suggested to predict individual variation in TP metabolism and response to therapy. However, prospective data to confirm the clinical benefits of metabolites guided dosing is still limited. Guidelines around TP monitoring are also lacking. This study aims to evaluate current Australian gastroenterologists’ (GEs) practice in TP use for IBD, including TPMT testing, full blood count (FBC) monitoring, TP metabolites testing, and allopurinol combination therapy, and how these practices have changed clinical outcomes.

Methods: An anonymous survey was distributed to GEs by email and at various meetings across Australia over a 6 month period.

Results: 168 responses were received, of which 137 were complete. Most respondents (79%) tested TPMT levels, and most but not all tested this prior to initiating TP (89%). The majority still prescribed TP if TPMT levels were intermediate or low (98.4%; 71.3%), and were more likely to exercise caution by reduced dosing (57%; 96.6%) and/or increased frequency of FBC monitoring (34.7%; 73.6%). FBC monitoring intervals upon initiation of TP varied, especially in the 1st month. A vast majority (88%) used TP metabolites, and of these, 80.4% were using the results for metabolite guided dose adjustments to optimize response, not just for non-response to standard dosing. 88% have to wait more than 1 week for metabolite results. Those not testing metabolites cited lack of availability or cost as the main reasons, and almost all of these respondents would use it otherwise. The majority of respondents found that metabolite guided dose adjustments had improved clinical response rates, reduced complication rates (80.6% and 61.2% of respondents respectively), and had altered their clinical practice (79%). Allopurinol combination therapy was prescribed by the majority of respondents (71%), and of these, 83% would use it in “shunters” irrespective of liver function test abnormalities, whilst 36.6% would use it for TP side effects irrespective of metabolite levels.

Conclusions: The vast majority of Australian GEs are using TP metabolite monitoring, or would, were it more readily available. The majority are using metabolite guided dose adjustments with associated subjective improvements in clinical response rates and reduced complication rates. Allopurinol combination therapy is also used by the majority of GEs. Prospective data to confirm what is reflected in current practice and standardized recommendations for TP metabolite monitoring and allopurinol combination therapy are rapidly awaited.

P312
Thiopurine metabolite testing in inflammatory bowel disease

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Background: The thiopurines are established, cost effective therapies in IBD. However drug toxicity and lack of efficacy are significant problems. The traditional approach has been weight based dosing. More recently thiopurine metabolite testing has been introduced but it is unclear whether achieving a